Patient Registration

525 West 98th Street, Bloomington, MN 55420

Oxboro Dental Care

952-881-2243
www.oxborodentalcare.com

Patient Information:

_____/_____
patient's name, last first initial birth date

_____/_____/_____/_____
street address city state zip

_____/_____
social security number home phone

_____/_____/_____
employer occupation work phone

_____/_____
email address how did you hear about our office?

_____/_____
person responsible for account, if different from above home phone

_____/_____/_____/_____
street address city state zip

_____/_____/_____
employer occupation work phone

_____
email address

_____/_____/_____
name of person to contact for emergency relationship home phone

_____/_____/_____/_____/_____
street address city state zip work phone

For Patients with Dental Insurance: Please present your insurance card for us to photocopy. It is assumed that you do not have dental insurance if this information is not on file.

Insurance Records Release and Assignment of Benefits:

I authorize Oxboro Dental Care to release to any insurance company, health plan, worker's compensation carrier, Medical Assistance, or any other payer, any information needed to determine benefits for services provided. I assign the authorized benefits and direct that payments under any insurance policy or health benefits plan be made directly to Oxboro Dental Care for any services rendered to my dependents or me.

Signed:_____ Date:_____

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Dental History:

Yes **No** Are you having any dental problems at this time?

_____

if yes, please describe

Yes **No** Have you had orthodontic treatment (braces)?

Yes **No** Have you had oral surgery (extractions)?

Yes **No** Have you had gum treatment (periodontal scaling or surgery)?

Yes **No** Have you had your bite adjusted (occlusal adjustment)?

Yes **No** Have you worn a bite plane or an appliance to treat you for grinding your teeth?

Yes **No** Have you noticed any loosening of your teeth?

Yes **No** Do your gums bleed when you brush your teeth?

How often do you brush your teeth?_____

How often do you floss your teeth?_____

Yes **No** Do you have any sores or lumps in or near your mouth?

Yes **No** Are you dissatisfied with the function of your teeth?

Yes **No** Have you ever experienced pain or clicking in your jaw?

Yes **No** Have you ever experienced difficulty in opening or closing your jaw?

Yes **No** Have you ever had any head, neck, or jaw injuries?

Yes **No** Do you clench or grind your teeth while awake or asleep?

Yes **No** Do you frequently bite your lips or cheeks?

Yes **No** Have you ever had an upsetting experience in a dental office?

Yes **No** Is it important to you to keep your teeth?

Yes **No** Are you dissatisfied with the appearance of your teeth?

Yes **No** Have you ever wanted to have straighter, whiter teeth?

Yes **No** Is there anything about having dental treatment that bothers you? If yes, please describe:

_____

Date of last dental cleaning_____

For Women Only:

Yes **No** Are you, or do you think you might be pregnant?

_____

If yes, when is your baby due?

Yes **No** Are you nursing?

Yes **No** Are you taking birth control pills?

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Medical History:

Yes **No** Have you been under the care of a physician in the past two years?

_____/_____
Physician's name office phone

Yes **No** Are you taking any medication, drugs, or pills? If yes, please list:

_____

_____

Yes **No** Are you allergic to any medication? If yes, please list:

_____

Yes **No** Are you allergic to latex?

Yes **No** Do you use tobacco?

Do you have, or have you had, any of the following:

Yes	**No**	Angina Pectoris/ Chest Pains	**Yes**	**No**	Heart Disease/ Attack
Yes	**No**	Arthritis	**Yes**	**No**	Heart Failure
Yes	**No**	Artificial Joints – Date:_____	**Yes**	**No**	Heart Murmur
Yes	**No**	Artificial Heart Valve	**Yes**	**No**	Heart Pacemaker
Yes	**No**	Asthma	**Yes**	**No**	Heart Surgery
Yes	**No**	Chronic Cough	**Yes**	**No**	Hepatitis/ Jaundice
Yes	**No**	Cold Sores/ Fever Blisters	**Yes**	**No**	High Blood Pressure
Yes	**No**	Congenital Heart Disease	**Yes**	**No**	Kidney Disease
Yes	**No**	Cortisone Medicine	**Yes**	**No**	Mental/ Nervous Disorder
Yes	**No**	Diabetes	**Yes**	**No**	Mitral Valve Prolapse
Yes	**No**	Drug Addiction	**Yes**	**No**	Psychiatric Treatment
Yes	**No**	Emphysema	**Yes**	**No**	Radiation/ Chemotherapy
Yes	**No**	Epilepsy/ Seizures	**Yes**	**No**	Rheumatic Fever
Yes	**No**	Fainting/ Dizzy Spells	**Yes**	**No**	Sinus Problems
Yes	**No**	Glaucoma	**Yes**	**No**	Stroke
Yes	**No**	HIV Positive/ AIDS	**Yes**	**No**	Thyroid Problems
Yes	**No**	Hayfever/ Allergies/ Hives	**Yes**	**No**	Tuberculosis
Yes	**No**	Head Injury	**Yes**	**No**	Ulcers

Yes **No** Do you or have you had any disease, condition, or problem not listed? Please describe:

_____

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Authorization for Communicating Health Information:

I hereby authorize Oxboro Dental Care or its staff to leave messages regarding future appointments or antibiotic pre-medication on an answering system or with people at my home. I understand that such a message will be limited to a reminder, and will not contain any detailed medical information.

Signed:_____ Date:_____

Acknowledgment of the Nature of Dental Treatment:

I understand that no guarantee or assurance has been given by anyone as to the results that may be obtained by my consent to treatment.

Signed:_____ Date:_____

Cancellation or Failure to Keep Appointments:

I understand that Oxboro Dental Care reserves the right to assess a charge for failure to keep appointments, or failure to cancel or reschedule 24 hours prior to my appointment time.

Signed:_____Date:_____

Responsibility for Payment:

I understand that I am responsible for all charges for services rendered to me or my dependents by Oxboro Dental Care. Oxboro Dental Care will process insurance claims and submit them to my insurance carrier. If for any reason any portion of these charges is not paid by my insurance carrier, I remain responsible. Oxboro Dental Care does not represent any insurance carrier and makes no representation as to what services will or will not be covered by my insurance. Any "estimate" I receive from Oxboro Dental Care regarding my insurance payment is, as stated, an "estimate". It is based on information supplied by my insurance carrier, and may not include any limitations or restrictions set forth in my policy. Any disagreements I may have about which procedures have or have not been covered must be resolved with my insurance carrier, but do not change my responsibility for all charges incurred.

Late fees may be assessed monthly for any balance over 30 days. Additionally, any costs incurred in collecting a past due account will be my responsibility, which may be based on a percentage at a maximum of 33% of the debt, and may include reasonable attorneys' fees.

Signed:_____ Date:_____